

Request for Similac Formula



Participant Name: _____ Date of Birth: _____ Today's Date: _____

A. Formula (Required)		
Prescribed Amount: <input type="checkbox"/> Maximum Allowable OR _____ per day		
Formula (select one):	Reason for issuance:	Length of time formula is required:
<input type="checkbox"/> Similac Sensitive (Low lactose) <input type="checkbox"/> Similac Total Comfort (Partially hydrolyzed whey protein, low lactose) <input type="checkbox"/> Similac for Spit Up (Rice starch added, low lactose) No other formula may be requested with this form.	<input type="checkbox"/> Malabsorption <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Reflux <input type="checkbox"/> Colic <input type="checkbox"/> Other: _____	<input type="checkbox"/> Until first birthday (end of the month) <input type="checkbox"/> Other date _____
B. Supplemental Foods (for Infants 6 months and older)		
Infants (6-12 months): <input type="checkbox"/> Provide full food package <input type="checkbox"/> Do not provide any foods at this time; issue formula only <input type="checkbox"/> Provide a modified food package including the following foods: <input type="checkbox"/> Infant cereal <input type="checkbox"/> Infant vegetables/fruit		Special Instructions/Restrictions:

Health Care Provider Name (Printed): _____ (Signature): _____ Phone Number: _____

Submit to: Local agency: _____ Phone Number: _____ Fax Number: _____
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